

The Irish state's pact with private healthcare: Time for it to end

Marnie Holborow, in the first of three articles on the need for an All – Ireland National Health Service, explains how the state in the Republic has clung stubbornly to supporting private healthcare, depriving us all of a comprehensive and efficient public health system



The Covid 19 crisis has lifted the lid on the failures of the Irish Health system. It has shown that the most efficient way to deal with a crisis of this scale is to take things into public control. Even if the private hospitals have been paid a huge amount for access to their beds and facilities, the state take – over showed that nationalization is possible and can be done overnight, if necessary. The measure also made private health insurance redundant as the benefits of most health plans were no longer there. The insurance companies had to offer rebates which, in turn, has made people question the need for public health insurance at all. GP's for the first time were paid directly by the state for patients phoning in to the surgery for consultation. We got a glimpse, albeit in an incoherent and over-costly form, of how the public control of healthcare could greatly improve its delivery.

Fintan O'Toole makes the point that national emergencies make the unthinkable thinkable. It was the social crisis resulting from World War 2 that made a National Health Service in which everyone was to be given free access to basic treatment, seem obvious.¹

How health is organized can be understood as a relational process between humans and their societies, and an essential part of how societies maintain their working populations. The privatization of healthcare, which has spread across Europe's health services like a rash, erodes the concept of health as a public good and, as Lee Humber shows in his timely book *Vital Signs*, leads to greater health inequality.² Healthcare in Ireland has a specific historical legacy which allowed a large non-public component to expand, which has facilitated the greater marketisation of health and the expansion of

private hospitals.

In the shadow of the Covid crisis, and a campaign for an All-Ireland National Health Service already underway, it is important to understand the role that the Irish state has played in backing the interests of health profiteers. What is urgently needed is for the state to withdraw its support for the fee-paying, private healthcare and to co – fund a national health service for the whole of the island which guarantees free and equal access to all.

Reform blocked

Barriers to free access have existed over many decades in the Irish health system. Even before the foundation of the Irish State, in 1911, the Catholic Church and the medical profession, with the support of Irish MPs in Westminster, successfully prevented the extension to Ireland of free GP care and medication introduced in the rest of the UK.

Common throughout the period from 1911 to 2011, as health researchers Maev-Ann Wren and Sheelagh Connolly note, 'was a fundamentally libertarian perception of healthcare as a marketable commodity rather than a right'.³ Both Southern ruling parties resisted the reform adopted by other states which, by the mid twentieth century, were moving towards more comprehensive health systems funded by social insurance and taxation. When popular pressure led to the foundation the NHS in the UK, in Ireland, in 1951, a reactionary alliance of the Catholic Church and doctors, backed by a Fine Gael Taoiseach and Ministers, prevented the introduction of the Mother and Child scheme. This would have offered free primary care to

children and free care to mothers before and after birth.

The fee-paying principle remained paramount. In the 1960's, when even the Catholic Church moved to a social reform position regarding access to healthcare (with the exception of women's health), the Irish state continued to block reform to remove private fees. For example, in 1974, it towed the line of the hospital consultants who threatened to strike if fees were removed – and they were not.⁴

State-private overlap

The Irish hospital system has a very tight public-private overlap. HSE hospitals are publicly owned and funded; so-called voluntary hospitals are publicly funded but owned by religious or lay trusts; and so-called private hospitals are owned and funded privately. In other words, there are Public Hospitals, Private Non-For-Profit Hospitals and Private For-Profit Hospitals. Before the pandemic, the shocking fact was that public Irish hospitals controlled just 49.35% of the national bed stock, while both types of private hospitals had 51%.⁵

Even these classifications can be misleading. The Bon Secours hospitals are a case in point. They are owned by the religious order of the same name, they have five hospitals, in Dublin, Cork, Limerick, Galway and Kerry. They are the largest private healthcare provider in the State with, somewhat incongruously, corporate heavyweights former AIB Chief Executive Michael Buckley and PwC partner Peter Lacy on their board. Bon Secours is listed as a not-for-profit organisation but, ironically, finds itself in the top profits league. In 2018, its turnover was €286 million and it had accumulated profits of €85.7 million.⁶ To think that it was this religious order which refused to pay the full costs of investigation into the cruelty inflicted in the Tuam Mother and Baby home only makes their mega profits more shocking.

The Irish state presents itself as adopting a hands-off approach to the private and voluntary sector; in reality, it directly boosts for-profit healthcare.

The Irish state provides huge tax incentives for investors in For-Profit hospitals. Between 2002 and 2010, the government implemented a programme of tax incentives for investors in Private For-Profit hospitals. For every €100 million of capital put into hospital construction, the government offered €44 million in

tax breaks to investors. This led to the rapid growth of Private hospitals.⁷

Private Health Insurance

The Coronavirus crisis has shone a light on other inconsistencies of the state-private nexus. Private Health Insurance – excessively expensive and poor value at the best of times – was revealed in the pandemic as useless.

45% of the population in the South today have private health insurance. The percentage of citizens in the North signed up to VHI, one of the region's primary health insurance providers, is 10%. This tells you something about the state of our public health system in the south.

PHI rates are high even though, in theory, everyone has entitlement to public hospital care from the state. Hospital care is what private health insurance mostly covers. The insured can avail of "private" health care, although much of this private care is actually delivered in public hospitals.

The reason that people on even modest salaries take out private insurance is fear. With long waiting lists, they believe that private insurance is a way of ensuring that if they fall sick, they will get a bed quicker. This is the perception even though the reality is that those with insurance may still be left waiting on trollies. Insurance costs a lot. The average premium paid per person in 2017 was €1,177 per annum and subscribers paid €2.53 billion in premium payments, one of the highest levels of coverage in the EU.⁸

The funding of Ireland's health care system is complex, opaque and wasteful. It comes primarily from Government sources, with significant contributions from out-of-pocket payments and private health insurance. Figures for 2016 show that 72% of current healthcare spending came from Government Schemes, 13% from Household Out-of-Pocket Payments and 12% from Voluntary Health Insurance Schemes. The remainder (3%) came from Other Voluntary Care Payment Schemes, which includes non-profit institutions and employer-provided healthcare.⁹ Austerity cutbacks contributed to the proportion of Irish health spending coming from private sources, increasing from 21% in 2008 to 30% in 2014, one of the highest ratios of private funding in the EU-15.¹⁰

It is the policy of the Irish state to keep up the numbers of people paying Private Health Insurance,

reflected in its granting of tax relief for those with PHI. It has been calculated that these tax exemptions represent a cost of at least €445 million to the state in any one year¹¹ – money which could be spent more usefully on the public health system. Moreover, the cost charged to private insurers for accommodation of patients in public hospitals remains below the full economic cost. Government support for private health insurance maintains private sector profit making, both for private healthcare and increasingly the global insurance companies, but it also has the side-effect, perversely, of keeping the public health system inefficient. As Brendan Howlin once remarked, if the public system were first rate, why would you pay for a private system?

Commitment to maintaining high levels of Private Health Insurance continues today. As Wren and Connolly point out, in 2017 a proposal to remove tax subsidies for private health insurance was opposed by government ministers, Varadkar and Harris, which resulted in it being voted down in the committee stages of Sláinte care.¹² Despite an outward commitment to universality, in practice the old two-tier regime wins out.

Consultant privilege

In 1991, under a Haughey government, two-tier access to hospitals was institutionalised by upholding the special entitlement of public hospital consultants to earn private fee income – a privilege unthinkable for other public sector employees.

Private consultancy work is deeply embedded in the Irish system. In 2017, 94% of consultants in Irish public hospitals had private practice entitlements in their contracts.¹³ In 2019, when nurses low pay was hitting the headlines, three hospital consultants earned an average of almost €500,000 a year, alongside a total of thirteen hospital consultants who had an annual income of €300,000, according to data provided by the HSE.¹⁴ Private medicine is very profitable business.

Irish Governments have bent over backwards to support the interests of consultants. Even the Sláinte care plan, which has the goal of removing private practice from public hospitals, proposed new consultant contracts of €222,000, rising further to €252,150 by July 2022 – huge salaries by any measure. During the Covid crisis, consultant privilege resurfaced. They had been offered a locum contract under which they could see

only public patients and would be paid up to €195,000 per year yet the Irish Hospital Consultants Association refused point blank to cooperate. Imagine the reaction if other health workers had done such a thing? At the height of the pandemic crisis, while others were giving their all, the consultants' status and wealth came first. As Veronica Keane, consultant psychiatrist and founder member of the All-Ireland NHS campaign, noted ruefully at a recent public online meeting, progressive consultants in Ireland are few and far between; any reform of the Irish Health Service will have to take their wealth and privileges head on.

Making delays pay

The National Treatment Purchase Fund (NTPF) acts as another means of siphoning public money to the private sector. Through the NTPF, the state can buy packages of care, including private hospital accommodation and treatment for patients by consultants. It has become the main mechanism for reducing public waiting lists. It allows taxpayers' money, which could otherwise be spent on improving our public health system, to flow into private hospitals. The NTPF, hailed as the answer to waiting lists by mainstream politicians (in particular, Micheál Martin, whose party was responsible for its introduction) entrenches private hospitals in the system and continues to provide no incentive to improve public bed capacity, facilities or staff numbers.

Sara Burke, Ruairí Brugha and Steve Thomas, who have researched the NTPF, point out that even in its own terms it is a policy failure. Waiting lists have escalated, not reduced, since its introduction. In 2008, the numbers of adults and children waiting for inpatient and day-case public hospital treatment were just over 40,000. Ten years later it was at just over 70,000.¹⁵ The aim of the NPTF was that no one would wait for more than three months for treatment and this has clearly not been achieved. In the first five years, it did take some pressure off the hospital system. But long waiting times of over 12 months (which are very unusual in the international context) persist, a decade after it was established.¹⁶ 2019 figures from the NTPF show just how bad things have become: Outpatient waiting lists have increased, year-on-year, since 2014, with the largest percentage increase between 2016 and 2016 (14.3%), and an overall increase between 2014 and 2019 of 47.5%.¹⁷

The NTPF is a policy of privatization by the back door. It was introduced under the FF-PD government and followed the dominant neoliberal thinking at the time, which was to cut back on the welfare state. As Burke *et al* reveal from their research of working groups charged with drawing up the NTPF, the principle of public-private mix in healthcare was taken for granted. When the question was raised at one 2001 Departmental meeting about why on earth the state should be subsidizing queue jumping, the riposte was that ‘the consultants would bring the system to a halt; they would game the system and destroy it in order to maintain their highly subsidized private work’. Apparently, it was then that Taoiseach at the time, Bertie Aherne, jumped in and said ‘If we pick a fight with the consultants, they will destroy us.’¹⁸ How little things have changed.

Upping the NTPF game

Neoliberal thinking continues to inform government policy. As part of the Sláinte care plan, Budget 2020 increased the funding for the National Treatment Purchase Fund, bringing the total funding to €100 million in 2020. Both Fianna Fáil and Fine Gael were only too aware that the hospital crisis was already a number one worry for voters in the last General election and their instinct is to extend the NTPF market solution. Now as the Covid crisis morphs into the backlog of treatment crisis, the Government, again wants to ramp up the operation of the NTPF. It has signaled its intention to use NTPF to replace the expensive deal with private hospitals – itself likely to end up around €338 million – allocating now possibly as much as €500 million to the NTPF. Caretaker Health Minister Simon Harris may have declared at the beginning of the crisis that there can be no public private divide in dealing with Covid. What he did not mention was his willingness to pay through the roof to keep the private sector happy.

It should also be remembered that the NTPF plays a role in state payments to private nursing homes. The NTPF contracts with the nursing homes and sets the prices paid. The HSE then makes a clinical assessment of the individual and a financial means test. As Tony O’Brien, former HSE chief, admits, although the HSE pays the bills, it has no role in deciding which nursing homes are used or at what cost.¹⁹

But the NTPF’s role does not include setting standards for private residential facilities. The NTPF

operates under the misnamed Fair Deal scheme, which came into effect in 2009. It allows payment to care homes to be as much as 80% of income, (along with 7.5 per cent per annum of savings in excess of €36,000 and, for the first three years, 7.5 per cent of the value of the person’s home). The scheme has accelerated the privatisation of care homes, as the figures show. In 2008 public provision accounted for 29% of nursing home beds by 2013 that proportion had reduced to 23.1%, with the voluntary sector accounting for 10% and the private sector, for 66.8%²⁰ It should be added that the state also designates nursing homes “industrial buildings”, making them eligible for tax breaks against construction and refurbishment, and also gave them a further tax break in 2016 under the Employment and Investment Incentive Scheme.

Cross border market

A similar operation to the NPTF exists in the form of the EU approved Cross Border Directive. This was a scheme championed by former Irish Attorney General later to become EU Commissioner for Health and Consumer Protection, David Byrne. It allows patients to travel north for cataract operations and hip and knee replacements. It is another state-funded mechanism to get patients off public waiting lists.

Under the directive, an eligible patient can pay for treatment in the North and be refunded by the HSE afterwards. Expenditure on the scheme grew from €29,265 in 2014 to over €12million last year. It could end up at close to €20 million this year – the end of October total was close to €10m but over 3,000 people are awaiting reimbursement. A similar process applies to patients in the North with the National Health Service although this is less used because a consultant’s referral is needed, unlike for the South where just a GP referral suffices.

Again, it is For-Profit healthcare that benefits. The Kingsbridge Private Hospital in south Belfast has significant involvement in the scheme, accounting for over 60% of the HSE’s Cross Border Directive related expenditure. Before Covid, Kingsbridge regularly received busloads of patients, (coordinated, incidentally, by Cork South West TD Michael Collins and the Kerry Healy-Raes). RTE, a state company, sings the praises of the private healthcare service on its website, believing it to be, along with Simon Harris a no brainer solution to

wait times for care.²¹

However, this only makes things worse. People must have the money to pay up front, may have to wait some time for reimbursement and may have a long way to travel for the procedure. We should be demanding access to these basic procedures as a social right. Making these services a market commodity with a price tag lets the government off the hook and overall health provision goes backwards.

One Public System

Government thinking is premised on the neoliberal belief that the private is more efficient, provides a better experience for the 'client', and that when you pay for something you get a better service. However, private health care, counter to the dominant narrative, perpetuates greater inefficiencies and generates more wasteful costs. The most expensive healthcare system in the world is the most privatized – that of the US. The American state spends 17.8 % of GDP on healthcare, well above the average of 9.9% which EU countries spend.²² It is also the most inefficient. It is weighed down with administration, bureaucracy, endless forms to fill in for insurance companies. People in the US dread falling sick and delay visits to the doctor because healthcare is so expensive.²³ Less public health provision means poorer health outcomes. In the US where in 2018, another \$15 billion was cut from the public provision of health, the lack of a comprehensive public healthcare system has allowed it to have the highest numbers of fatalities from Covid 19 but also the highest amongst the poorest. Access to healthcare is a major political issue and fed into the growth of radical opposition to the current Trump regime.

Into the future, the question of hospital capacity here will intensify. Social distancing and infection control measures will radically reduce the capacity of the acute hospital system. Pre-Covid, the Irish system already had a much higher bed occupancy (at 100%) than international norms (85%). Necessary decontamination down-time will reduce capacity further and reduce usage of equipment. More step-down facilities will have to be found to free up the overall fewer hospital beds that social distancing will require.

In this continued emergency, the way to increase capacity is an overall comprehensive investment to increase bed capacity and efficiency in the public

hospitals, not throw more money at private facilities. We need the efficiency of one coordinated system not three or four fragmented ones. This means not paying exorbitant rent for private hospitals but their nationalization. It requires the requisitioning of other private facilities for non-ICU and isolation capacity. Incorporating into the public system other facilities, such as City West Hotel with its 700-bed capacity, as happened at the beginning of the Covid crisis is an obvious way – minus the high rental costs – to contributing to a permanent solution.

Post-COVID more people want to see change. Amongst GPs there is beginning to be a greater acceptance that the fee for service system is inefficient. In 2015, more than 92% of GPs signed up to a contract to provide free GP visits for children aged under six despite the proposal initially being opposed by some GP organizations. During the pandemic, more people see the sense of health must be delivered not in free standing private profit-making units but as an overall whole, in one system on an island of 6.6million people and an integration of all healthcare, social and community included.

The present obsession of the caretaker government, as pointed out here, is to fund the private healthcare, which allows public funds to flow out of public healthcare and perpetuates the inefficiencies of the public system

It has pursued this policy in tandem with downgrading healthcare workers. Despite its recent posturing about essential workers, it has refused to give pay rises or provide appropriate salary scales. The number of staff nurses fell by 1,754 or 6% between 2008 and 2018 despite the greater demands on the health service.²⁴ A core 'cost' for private care institutions is the investors' dividend not the level of care. This has resulted in low pay for carers and nurses and tragically high numbers of deaths in those care homes during the pandemic.

There is an irresolvable conflict between profit-making and the maintenance of public health, a fact that Fine Gael and Fianna Fáil, both driven by neoliberal pro-market ideology, refuse to recognise. Removing tax subsidies for private healthcare and diverting all state funds and supports towards a fully public health system will come up against the tax haven orthodoxies and the entrenched interests of Irish capitalism. It is up to the campaign for an All-Ireland National Health Service to take forward the opposition to this political

order – expressed so forcefully at the last election – and mobilise it for one fully public health service, with free access for all.

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- 6 Mark Paul 'Who Owns private hospitals behind State' €115m-a-month deal? *The Irish Times*, April 19, 1920
- 7 Julien Mercille 2018, p 2
- 8 Martin Wall, '46% of population covered by private health insurance as market grows', *The Irish Times*, 19 July 2017
- 9 These figures thus broken down do not make visible government supports in the form of tax relief to the so-called private sources.
- 10 Brian Turner, 'Irish Benchmarking of the Structure of Irish Healthcare', in *The Irish Healthcare System: A Historical and Comparative Review*, The Health Insurance Authority Dublin, 2018, p.48.
- 11 Mercille, pp. 1-2
- 12 Maev Ann Wren and Sheelagh Connolly *Universal Health Care in Ireland—What Are the Prospects for Reform?* Economic and Social Research Institute, Dublin, Ireland 2019, p 96.
- 13 OECD Report, Assessing Private Practice in Public Hospitals, (2018) p 9. <https://assets.gov.ie/26530/88ebd7ddd9e74b51ac5227a38927d5f9.pdf>
- 14 Eilish O'Regan and Anne-Marie Walsh 'Three consultants earning €500,000 amid 'low morale of pay inequality'.
- 15 *Irish Independent* February 25, 2019.
- 16 Sara Burke, Ruairí Brugha, and Steve Thomas, 'The National Treatment Purchase Fund – A success for some patients yet a public policy failure?' *Administration*, Vol 67, No 2, pp 47-69, p 65.
- 17 Burke, Brugha, and Thomas, p 64.
- 18 Social Justice Ireland, 10 January 2020. <https://www.socialjustice.ie/content/policy-issues/outpatient-waiting-lists-increase-almost-50-health-service-crisis>
- 19 Burke, Brugha and Thomas, p 55.
- 20 Tony O'Brien, 'We need clear and deliverable actions for healthcare plans', *Sunday Business Post* June 7, 2020
- 21 Victoria White 'We must outsource eldercare but radically smash the current model' *Irish Examiner*, May 28, 2020
- 22 Tommy Gorman, 'The important truths about EU-Linked health schemes' *RTE*, 11 Dec 2019,
- 23 US figures CMS.gov figures 2018; European figures Eurostat 2017.
- 24 Niclas Olsen and Daniel Zamora, 'Pandemics Show how the Free Market Fails Us', *Jacobin*, 26 March 2020
- 25 INMO figures <https://inmo.ie/Home/Index/217/13444>

Notes

- 1 Fintan O Toole, 'It's time for an Irish National Health System', *The Irish Times* May 30, 2020
- 2 Lee Humber, *The Deadly Costs of Health Inequality*, London, Pluto Press, 2019.
- 3 Maev Ann Wren and Sheelagh Connolly, 'A European late starter: lessons from the history of reform in Irish healthcare', *Health Economics, Policy and Law*, Vol 14, Issue 3, 2019, pp 355-373.
- 4 Maev Ann Wren, *Unhealthy State -Anatomy of a Sick Society*, Dublin: New Ireland, 2003